Editorials

Building equity in the NHS:

the role of general practice

INTRODUCTION

The NHS promise of comprehensive health care based on need and free at the point of use trips off the tongue, but has been hard to deliver especially in primary care. Formula-driven resource redistribution has worked in the hospital sector, steadily shifting resource according to need as measured by mortality rates, but not in general practice, where the distribution of general practice funding remains out of kilter with social gradients in premature multimorbidity and mortality.[1,2] The metaphor of a level playing field does not apply. Health care is built on a slope. Life and work are easier at the top.

As Levene *et al* report in this issue of the *BJGP*,[3] the UK GP Contract continues to serve poor areas poorly. By using measures of activity as proxy measures of need, the funding formula rewards the expressed needs and demands which keep practices busy, such as the needs of patients who have acquired longevity and the demands of the worried well.

The unworried unwell, who often censor themselves, need a worried doctor but worried doctors need adequate consultation time, a long view, supportive colleagues, and effective referral links, all of which may be in short supply.

The Care Quality Commission (CQC, www.cqc.org.uk) rates 6947 general practices in NHS England in terms of being safe, effective, caring, responsive, and well-led — 90% are rated as 'good' and 5% as 'outstanding'.The high prevalence of 'good' practices provides an explanation of the inverse care law,[4] not in terms of the difference between 'good' and 'bad' medical care, but as the difference between what practices serving deprived areas can do and could do if they were better resourced.

THE GP CONTRACT AS A BLIND ALLEY

The difference is unlikely to be bridged via a GP contract that leaves it to individual practices to decide how much practice income is 'profit' and how much is to be spent on service delivery. The 2004 contract was celebrated in some quarters as having pulled the wool over the eyes of Department of Health negotiators by incentivising performance targets that were already being achieved by many practices. Thus, a contract intended to improve patient care was considered by many as a pay rise. This was not a ruse that could be repeated. In the next decade, GP funding flat-lined, while funding for specialist services in primary and secondary care both increased by 50%.[5] With this pyrrhic negotiating victory, general practice shot itself in the foot.

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Even with political will the prospect of addressing the inverse care law via the GP Contract is not bright. Information on unmet need or, more accurately, poorly coordinated care, is obvious to frontline practitioners but absent from the routine data that statistical formulae require. Redistribution within a common budget when everyone is under-resourced and under pressure is also unlikely. As Adam Smith indicated in his works, perceived losses are felt, and therefore resisted, more keenly than perceived gains.[6]

These are old arguments, weakly competing for attention amid the many urgent challenges facing the NHS and its practitioners. Corporate predators are circling and waiting for opportunities to syphon off profitable parts of health care. General management has hypertrophied and, in the manner of hypertrophied organs, is working harder and harder to achieve less and less. Specialisms in both primary and secondary care have proliferated, providing high-quality care for patients who need them but fragmenting the care of patients with multimorbidity and excluding patients who do not 'fit'. Under-investment in generalist care in the community has weakened its ability to prevent, postpone, or delay disease complications and puts increased pressure on emergency departments. Trumping all these issues, there is a manpower crisis in general practice. If sufficient numbers of GPs cannot be recruited and retained, the whole service is at risk. Addressing the inverse care law in the future depends crucially not only on funding, but on a motivated workforce. But, motivated to do what?

The NHS has been insufficiently imagined as an agent of social justice. Health care in deprived areas is a holding operation, avoiding the disgrace of open gaps but failing to achieve what could be achieved. As the title of Bevan's book *In Place of Fear* made clear, removal of financial barriers to health care was a huge step forward, but it only provided access, and not necessarily needs-based care.[7] A continuing issue is whether the NHS is primarily for those who have achieved longevity or also an instrument for reducing differences in longevity between social groups — the starkest form of social exclusion.

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THREE BUILDING PROGRAMMES

The exceptional potential of general practice was originally described in terms of what could be achieved in individual consultations.[8] Initial engagement is essential, but only the starting point for three building programmes, none of which involve bricks and mortar. All require purpose, patience, and persistence in building new relationships.

First, using serial encounters, the challenge is to build a practice compendium of strong patient narratives, especially for patients with complex multimorbidity, based on what is important to them. Self-help and self-management are destinations, not starting points, for many, and are only achievable after time is taken to build knowledge, confidence, and agency.

" ... if the NHS is not at its best where it is needed most, inequalities in health will widen."

Second, the intrinsic strengths of general practice, including an unconditional approach, continuity, coverage, long-term relationships, and trust, make it the natural hub of local health systems, but effective hubs need to build strong relationships and quick, familiar referral links to community resources and other local services. As an example, financial advisers embedded in general practices, and not simply 'co-located', resulted in many patients claiming welfare benefits to which they were entitled, with an average annual financial benefit of £8253 per claimant.[9]

Third, local health systems need to be part of a whole system, connected by a collegiate culture of shared experience, evidence, and learning. General practices should be accountable not only upwards to their source of funding and downwards to the populations they serve, but also horizontally to each other, supporting weak links in the chain.

Such building programmes can and must be supported from the centre, but their detail and implementation can only be imagined and led at local level. GPs can embrace or block such change. They also need to stay long enough in one place to make a difference, drawing compound interest from social capital.

As multimorbidity accrues, such building programmes are needed everywhere, but if the NHS is not at its best where it is needed most, inequalities in health will widen. There are three cogent reasons for beginning at the bottom of the slope. For health service managers, stronger care in the community can prevent, postpone, or lessen personal crises requiring emergency A&E attendance or hospital admission. The recent evaluation of Sure Start by the Institute of Fiscal Studies showed this for vulnerable families.[10] General practice needs similar evidence.

For an increasing group of Deep End practitioners, including newcomers and old hands, this is what they already aspire to do, it is the direction they want their careers to take and it is the collegiate culture they want to be part of.[11,12]

But third, and most important, it is what publicly funded doctors can contribute to society. Julian Tudor Hart maintained and demonstrated throughout his career that the NHS could and should be a model for wider society, as a gift economy based on giving as well as getting.

Inclusive health care, excluding exclusions and building relationships, is a civilising force in an increasingly dangerous, divided, and uncertain world.

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